MAP-4095 (Rev. 9/2004)

PASRR SIGNIFICANT CHANGE/DISCHARGE DATA

Resident Name: _____

Date of Birth: ____/____/____ **Social Security #:** _____

Facility: _____ **ID#:** _____

"Significant change" means that the individual's mental or physical condition has changed significantly in a manner that affects his/her need for specialized services or might no longer meet Medicaid criteria for nursing facility level of care. If any of the following events have occurred, please check the appropriate choice and forward this form to your local Community Mental Health/Mental Retardation Center within twenty-one (21) days. The Level II PASRR shall be completed within nine (9) working days upon receipt of this form.

Type of change:

☐ Resident has a mental illness with active symptoms.

☐ Resident has a mental illness and the medical condition for which he/she was admitted has significantly improved.

☐ Resident has mental retardation or developmental disability and the medical condition for which he/she was admitted has significantly improved.

☐ Resident has mental retardation or developmental disability and now requires more intensive services than a nursing facility setting can provide.

☐ Resident has mental retardation or developmental disability and receives specialized services and medical condition has significantly declined.

☐ None of the above. No referral required.

Type of Discharge:

☐ Deceased

☐ Discharged: (Please check the appropriate discharge location)

1. ☐ NF Setting: ☐ KY ☐ Out of State
2. ☐ PC Setting 3. ☐ Supports for Community Living
4. ☐ Group Home 5. ☐ Foster Care Home
6. ☐ Other Community Setting (specify, if possible) _____

_____ ____/____/____

Signature of Facility Representative Date

***Mail completed form to your Regional PASRR office.**